

# *Co-Occurring Disorders: Integrated Dual Disorders Treatment*

*Implementation Resource Kit*



DRAFT VERSION

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## Implementation Tips for Mental Health Program Leaders

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This document is designed to help mental health program leaders who are planning to implement Integrated Dual Disorders Treatment at their clinical sites. Over the years, different leaders have used a variety of strategies to put integrated treatment into action. This document presents ideas gathered from mental health program leaders who have successfully implemented this treatment practice. Integrated Dual Disorders Treatment is the provision of mental health and substance use treatment services from the same clinician or treatment team.

### **Leadership**

The implementation of Integrated Dual Disorders Treatment is most effective when one person leads the effort. This individual must have the backing of senior administrators and the respect of direct treatment staff.

A client-centered approach to management that encourages leaders to focus on clearly articulated client-centered goals and to use consumer outcome data to guide ongoing management decisions is recommended. Progress and success are measured by consumer outcomes (in this case people who are making demonstrable progress in recovering from substance use disorder) rather than by process measures such as hours of therapy.

## Phases of Change

The process of implementing integrated dual disorders treatment can be divided into three phases:

1. building a consensus for change,
2. making the change, and
3. sustaining the change.

Other mental health program leaders have found the following strategies helpful at each phase.

## Building a Consensus for Change

### *Vision*

It is important for the chief executive officer of your agency to articulate the vision for Integrated Dual Disorders Treatment throughout the agency, with all stakeholders, and to the public.

### *Concept of Recovery*

Help everyone to conceptualize Integrated Dual Disorders Treatment within the larger context of recovery. People with severe mental illness and substance use disorder need to learn to manage both disorders in order to pursue their own goals and have a good quality of life.

### *Involvement*

Involve key leaders from different stakeholder groups early in the planning process: consumer leaders, family leaders, team leaders, clinical leaders, and program leaders.

### *Discussion*

Organize meetings and retreats for education, discussion, and planning the implementation. Educate clinicians and team leaders about studies that demonstrate the effectiveness of Integrated Dual Disorders Treatment. Be certain to discuss the common arguments for and against Integrated Dual Disorders Treatment.

### *Speakers*

Bring in speakers who will inspire the staff, consumers and family members. Speakers should have credibility based on clinical experience; understand the relevant issues; endorse recovery-centered

values; and work well with families and consumers. Connect your clinicians with people who have similar roles at programs with established Integrated Dual Disorders Treatment. Case managers like to hear from case managers providing this treatment, nurses from nurses, and so on. Similarly, consumers who are in recovery from dual disorders and their families can give testimony about their experiences and answer questions about treatment. This strategy is most effective when used with all stakeholders.

### *Consultants*

In order to help anticipate and address the changes that will occur as a result of implementing Integrated Dual Disorders Treatment, it is useful to engage the services of a consultant or an evidence-based practices implementation center.

## **Making the Change**

### *Goal*

The process of care, from intake forms to program reviews, should be aligned so that the natural behavior for clinicians is to provide high-fidelity Integrated Dual Disorders Treatment.

### *Time frame*

It generally takes about a year for staff to feel comfortable and confident providing Integrated Dual Disorders Treatment, but the time frame can vary considerably.

### *Competence*

Every staff member needs to know the fundamentals of Integrated Dual Disorders Treatment:

1. information about alcohol and drugs of abuse, and interactions with mental illness,
2. assessment of substance use,
3. motivational interviewing, and
4. substance abuse counseling.

Additionally, staff members need to be aware of the supports available from a consumer's family or other supporters, and have a recovery orientation towards their work. All practitioners can learn these skills.

### *Staff size*

A program does not need more staff to provide Integrated Dual Disorders Treatment; the current staff members simply need to learn and develop new skills.

## *Organization*

Staff should optimally work in teams for the sake of clinical work, training, supervision, support, and morale. If each team contains at least one clinician with substance abuse treatment experience, staff can cross-train each other in the normal course of working together.

## *Training*

Initial training can be accomplished through a series of didactics and discussions. Resource kit materials are designed to facilitate this process. It also helps if clinicians can visit a functioning Integrated Dual Disorders Treatment program. Remember that these experiences just begin the process of training.

## *Supervision*

Clinicians learn new skills by doing their work in the context of good supervision. Supervision with an expert or with a group of peers should occur weekly.

## *Clinical team meetings*

Substance abuse should be addressed in all team meetings, whether the topic is assessment, treatment planning, or case review.

## *Equipment*

Mental health programs that implement Integrated Dual Disorders Treatments will increase the amount of substance abuse laboratory screening. Your program will need to explore the cheapest and most efficient ways of doing this. Many programs acquire their own testing equipment.

## *Paperwork*

Assessments, treatment plans, and progress notes must address Integrated Dual Disorders Treatments. Substance abuse must be a standard item on all forms.

## *Outcomes tracking*

People tend to recover from substance abuse in stages: engagement, persuasion, active treatment, and relapse prevention. The Stage of Substance Abuse Treatment scale (see Appendix) can be used for monitoring individual and programmatic outcomes. This data is also useful for client-centered supervision.

## *Policies and procedures*

Program leaders must review and revise all relevant policies and procedures to be sure that they support Integrated Dual Disorders Treatment implementation. Policies and procedures should include assessing and understanding what family and other supports are available for the consumer. The policies and procedures of other services, including housing, Supported Employment, Assertive Community Treatment, forensic liaisons, and other programs must be examined to work effectively with the Integrated Dual Disorders Treatment program.

## **Sustaining the change**

### *Provide data*

Provide all staff with outcome statistics (Stage of Substance Abuse Treatment) for the agency, and individual staff with outcomes for their clients on a regular basis. Line graphs show trends especially well. Some agencies prominently post relevant outcome statistics. This clearly reinforces the consumer-centered outcome goal of Integrated Dual Disorders Treatment.

### *Recognize staff*

Visibly acknowledge staff who have made Integrated Dual Disorders Treatment a success in your program, for example, with banquets to celebrate Integrated Dual Disorders Treatment achievements. Celebrations are particularly helpful when all stakeholders attend.

### *Celebrate success*

Find ways to share consumer success stories among staff, consumers, and family members when appropriate. Devote meetings to good news. This could include feedback and anecdotes from consumers, families, and employers.

### *Involve stakeholders*

Consumers in recovery and their families should be involved in active roles as the program develops. For example, recovering consumers can become group leaders, case managers, assistants, and advisers. Family members can similarly contribute in many ways.

### *Provide supervision*

Clinicians use new skills when they are addressed within the context of good supervision. Individual and team supervision structures are critical in reinforcing the use of new skills and helping staff to continually learn and develop Integrated Dual Disorders Treatment skills.

### *Review organizational policies and procedures*

Over time programs are sustained by structural mechanisms, such as financing, regulations, training and supervision, roles and responsibilities, record keeping, involvement of all stakeholders, and program reviews, rather than by charismatic individuals, or champions. As your Integrated Dual Disorders Treatment program develops, review all of these mechanisms regularly.

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# Appendix

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## Recommended Readings

(For additional references, please see the User's Guide.)

*The following publications are excellent resources on program management:*

- Batalden PB, Stoltz PK: A framework for the continual improvement of healthcare: Building and applying professional and improvement knowledge to test changes in daily work. *The Joint Commission Journal on Quality Improvement*. 19:10, 424–445, 1993
- Gowdy E & Rapp CA. (1989). Managerial behavior: The common denominators of successful community based programs. *Psychosocial Rehabilitation Journal*, 13(2), 31–51.
- Nelson EC, Batalden PB, Ryer JC (Eds): Joint Commission Clinical Improvement Action Guide. Oakbrook Terrace, Illinois, 1998
- Rapp CA: (1993) Client-centered performance management for rehabilitation and mental health services. In (Eds.) Flexer R & Solomon P, Community and social support for people with severe mental disabilities. Andover Publishing Co., Rehabilitation and Mental Health Service Delivery.
- Rapp CA. (1993). Client-centered performance management and the inverted hierarchy. In (Eds.) Flexer R. & Solomon P., Community and social support for people with severe mental disabilities. Andover Publishing Co.
- Rapp CA. (1998). The Strengths Model: Case Management with People Suffering from Severe and Persistent Mental Illness. Chapter 8 – Supported Case Management Context: Creating the Conditions for Effectiveness. New York: Oxford University Press.
- Supervisor's Tool Box. (1997). Lawrence KS: The University of Kansas School of Social Welfare.

*The following publications address Integrated Dual Disorders Treatment programs and implementation issues:*

- Drake RE, Essock S, Shaner A, Carey KB, Minkoff K, Kola L, Lynde D, Osher FC, Clark RE, Rickards L. Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services* 52:469–476, 2001.
- Mercer-McFadden C, Drake RE, Clark RE, Vervan N, Noordsy DL, Fox TS. *A Report for Administrators on Substance Abuse Treatment Services for Individuals with Severe Mental Disorders*. Concord, NH: New Hampshire-Dartmouth Psychiatric Research Center, 1998.
- Mercer C, Mueser KT, Drake RE. Organizational guidelines for dual disorders programs. *Psychiatric Quarterly* 69:145–168, 1998.